in time. When rare and exceptional patients appear we must study them carefully and report them with the notion that someone else may have had a similar experience. And when enough information accumulates, the pattern may be generalized, an idea of the pathogenesis and cause worked out and empirical treatment superseded by prevention.

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Yet Another Assumption About Health Care Costs

THERE IS GOOD REASON to be wary of the assumptions upon which the federal government bases many of its initiatives and interventions to control the costs of health care. The most recent assumes that, given the opportunity, consumers will be motivated to choose their health care plan or the health care they use on the basis of cost. The current rhetoric from the federal government seems to accept this as a given, even though what experience there is to date suggests that it may not necessarily be true. People do not always buy the least expensive vitamins, or even need vitamins at all, yet through personal choice many dollars are spent on vitamins and expensive ones at that. And experience with the Federal Employee Health Benefit Program and in markets with high health maintenance organization (HMO) concentration indicates that, in the past at least, consumers have not based their choice of plans primarily on economic factors.[1]

One is reminded of other assumptions by government that either have turned out to be wrong or seem likely to prove so. The widely publicized assumption that physicians' fees were the principal cause of rising health care costs certainly proved false, and the government's remedy certainly did not work. There are others that right now are in the process of not working very well or at all. For example, it has been assumed by the government that Professional Standards Review Organizations (PSRO's) would lower health care costs, that consumer dominated health systems agencies (HSA's) would reduce costs, that greater use of physician's assistants and other so-called midlevel practitioners would reduce costs, and that more competition among more doctors would reduce fees and therefore lower costs. So far none of these initiatives or interventions have fulfilled the expectations of government and many have actually added to the total cost of health care.

This most recent assumption is now to be tested —probably also on a massive scale. If consumers should happen to choose what they considered the best health plan rather than the cheapest, the result could easily be that this assumption too will not fulfill the government's expectations and may even add to the total cost of health care. It sometimes seems almost as if some of the important health policy makers live in a fantasy world where things are as they wish they were, rather than in a real world where they are as they are. This could also explain why many things have come to be as they now are.

—MSMW

REFERENCE

1. Competition in health care—A buzzword for the 1980s. Socioeconomic Report, Bureau of Research and Planning, California Medical Association, Vol 21, Jul-Aug 1981

Tests of Pancreatic Function

MANY CLINICIANS are wary of pancreatic secretory tests. These tests do not seem to be sensitive or specific enough to warrant the time, patient discomfort, special expertise or expense that they require. The multitude of proposed tests, skeptics say, supports their contention that a good pancreatic function test has yet to be invented.

Elsewhere in this issue, Goff reviews the various available tests. By their very nature, most are not likely to be precise. Tests measuring hydrolysis and absorption of orally administered compounds (triglycerides labeled with carbon 14, PABA-tyrosyl esters or radioactively labeled vitamin B_{12}) depend on many factors in addition to hydrolysis of the ingested substrate by pancreatic enzymes in the gut lumen. Gastric emptying, intestinal transit, postabsorptive metabolism and excretion of the test substance (in urine or breath) are all variables that may affect such tests of pancreatic function. Likewise, colonic transit and bacterial degradation are two extrapancreatic factors that may affect fecal concentrations of pancreatic enzymes. Duodenal intubation to measure the delivery of pancreatic enzymes close to their source eliminates many of these extrapancreatic variables; however, considerable imprecision is unavoidable. Results may be affected by dilution of pancreatic secretions with meal contents (in the Lundh test) or intestinal juices, autodegrada-